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Introduction

MAGDA FAHRNI AND ESYLLT JONES

It seems to me that everything that happens to us is a disconcerting mix of choice and contingency.

– Penelope Lively

Interpreting Pandemic Influenza, 1918-20

The 1918-20 influenza pandemic, which crossed the globe and left almost no society untouched, is perhaps the singular historical contingency of the twentieth-century world: what should have been a relatively innocuous disease developed a life of its own and affected society in unanticipated ways. Although often difficult to interpret, and poorly integrated into the major narratives of twentieth-century history, it nonetheless increasingly commands the attention of historians and the public. In the context of current anxieties and public discourses surrounding a global pandemic of H1N1 or another variant strain of influenza, influenza’s past is a topical subject of research. Indeed, the rise and fall of its history throughout the twentieth and early twenty-first centuries closely parallels patterns of broader public concern (or sanguinity) about a potential repeat of the 1918-20 pandemic. That all history is contemporary history borders on cliché for an influenza scholar.

The pandemic has been the subject of a rather large recent outpouring of popular works and has also been examined in a small number of English-language scholarly monographs (two of them Canadian), two major collections, and a significant body of articles.¹ Much of the scholarship on the pandemic is relatively new; a recent survey of the field concluded that “the overwhelming majority” of works on the subject were published during the last thirty years.² The present collection is a specifically Canadian
examination of the pandemic, joining such international analyses as those edited by Howard Phillips and David Killingray; the European experience is addressed in a collection edited by Fred R. Van Hartesveldt. Ours is a contribution to the history of medicine but also to Canadian social history more broadly. The authors gathered here are concerned with understanding the social structures and context in which the epidemic was rooted and experienced, and they look to social class, gender, ethnicity and race, age, and geographic location as key variables of analysis. Specific regions of Canada are studied here – British Columbia, the Prairies, Ontario, and Quebec – whereas a few authors (notably Mark Osborne Humphries and Linda Quiney) adopt a Canada-wide approach.

Like the field more generally, this collection is multidisciplinary, with contributors from a variety of fields including medical anthropology, geography, and history employing a diversity of methodological and interpretive approaches. It seeks to build on existing studies and introduces new work on the diffusion of the flu throughout Canada, taking us one step closer to a coast-to-coast picture of the pandemic’s history. The contributors engage with current themes and debates in the global pandemic’s historiography. Although some scholars have argued that influenza history is fragmented and lacks an overall synthesis or dominant “frame” of analysis (to use Charles Rosenberg’s now classic formulation), thoughtful historiographical critiques in the field, such as those by Phillips and Killingray, Svenn-Erik Mamelund, or Guy Beiner, continue to push researchers in new directions. Several themes have proven of particular interest to Canadian scholars and are reflected in this volume.

The first of these is the question of who contracted and died from influenza, and to what degree inequalities of race, ethnicity, and class led to differentials in mortality rates. In his 2006 article employing individual- and household-level data and mathematical analysis, Svenn-Erik Mamelund argues that there were socioeconomic differences in flu mortality in the city of Kristiania, Norway, challenging “the conservative view that Spanish influenza was an ‘egalitarian’ or classless disease.” Scholars in this collection, too, confront the notion that influenza was “democratic” in its effects. Their evidence reveals that race, social inequality, poverty, and pre-existing health crises all potentially played a critical role in shaping how individuals, families, and communities experienced the pandemic. Building on work by Mary-Ellen Kelm and Ann Herring on influenza in Aboriginal communities, where residents died at rates far in excess of non-Aboriginal Canadians, we explore here some of the reasons why this might have been the case.
Charles Rosenberg argued nearly twenty years ago that epidemics cut a “transverse section through society,” laying bare its structure and revealing its fault lines. Thus, a second area of interest is the social response to the pandemic, interactions between citizens themselves, and between citizens and state. Here, several of the essays shed new light on the experience of the epidemic “from below,” as well as “from above,” highlighting the role of non-state actors in attempts to address influenza and their interactions with government at various levels. These scholars reveal an active and engaged Canadian citizenry, commenting, often critically, on public health strategies or failures. Perhaps the most significant instance of civic engagement, in terms of coping with the millions of infected Canadians, was women’s volunteer and professional nursing. Among the contributions made by this collection, then, is an analysis of influenza’s history through the lens of gender.

Third, scholars in recent years have called for greater attention to the cultural history of influenza, particularly its long-term impact on memory, mourning, and modernity. This collection contributes to this debate through exploring individual and familial experiences of survival and grief, which challenge the public forgetting that has long surrounded the pandemic. In some ways, the crisis of 1918-20 might be seen as the last nineteenth-century epidemic: as these essays show, health professionals and political authorities were largely powerless to halt its spread and prevent its devastation. In laying bare the limits of modern medicine, the pandemic, like the Great War, demonstrated continuities with the previous century as much as it embodied twentieth-century modernity. The high level of volunteerism and the critical role of informal networks of care from kin and community, as revealed by several authors here, bring into critical perspective the elite-driven process of pandemic preparation in Canada today.

Although historians are often wary of applying “lessons” from 1918-20 to twenty-first-century public health strategies, the reality is that we are often called on to do so and are occasionally offended if our expertise is ignored. Thus, it is appropriate that this collection concludes with reflections on past and present responses to epidemic disease, including Canada’s experiences with SARS and the H1N1 influenza virus.

Influenza in Canada

In September 1918, Canadian newspaper journalists anxiously followed the spread of an apparently serious influenza epidemic through cities on
the American eastern seaboard. Appearing virtually simultaneously in Brest, Boston, and Freetown, South Africa, pandemic influenza killed perhaps 50 million people between 1918 and 1920 – most of them during the fall and winter months of 1918-19. Approximately fifty-five thousand of these deaths occurred in Canada, where the disease entered virtually every community across the country, no matter how remote from the centres of contagion. Although the pandemic’s less lethal spring 1918 wave had been barely noted in the press, and despite wartime censorship, Canadians were well aware of the extraordinary number of deaths that were occurring south of the border and on the battlefields of Europe during the month of September. One of the cruelties of the disease was that public health and medical personnel could do little to prevent its spread or to treat its victims.

In 1918, much like today, influenza was a deceptive and difficult-to-diagnose complaint, at times hard to distinguish from the common cold, with a reputation as unpleasant but only rarely fatal. For reasons that remain medically obscure, the variant of influenza that caused the pandemic was not so benign. For those most severely affected, what began as chills and aches could rapidly overtake the body, causing severe headaches, high fever, nausea, and vomiting. Victims might turn blue from cyanosis as their lung tissue deteriorated and their lungs filled with fluid, suffer from profuse nosebleeds, and cough up blood. Eventually, they would asphyxiate or suffer circulatory failure. Others were killed by secondary bacterial infections resulting in pneumonia, which was difficult to treat in this pre-antibiotic era. Influenza appears to have affected the brain and nervous system as well: sufferers exhibited psychosis and delirium, and some also experienced paralysis. The 1918-20 pandemic had a very high morbidity rate; perhaps as many as one-third of Canadians contracted it, although statistics on morbidity are notoriously unreliable. The proportion of people who died once infected was lower for influenza than for some other epidemic diseases such as cholera, for example. Yet, the flu pandemic was deadly because such great numbers of people became ill and because of the impact of secondary infections such as pneumonia.

Although the precise origins of the disease remain contested, most scholars agree that it originated in the military camps of the US Midwest, where it first appeared in March 1918. Between the spring and the fall of 1918, it mutated into a dangerous virus. In a globalized world closely connected by military, commercial, and personal networks of travel, it spread with all the speed of history’s great contagions. Recently, scholars have
paid particularly close attention to how the prosecution of the Allied war effort affected its path: Carol Byerly in the United States and Mark Humphries in Canada have focused a critical gaze on the decisions made by military leadership in this history. From overcrowded military camps in North America and overseas in Britain and Europe, where soldiers received mostly inadequate medical care and lived in unhealthy conditions, influenza gained its foothold. Byerly and Humphries both argue that Canadian and US military authorities sacrificed the health of their troops, and of civilians, to the war effort. Caught between the demands of winning the war and the threat of pandemic, they mobilized soldiers without observing the quarantines that might have slowed the transmission of the disease during its second, deadly wave. Canadian soldiers returning from Europe played a role in spreading the flu, which was reported among Ontario military camps by 19 September (see Chapter 9, this volume). It also spread from US to Canadian soldiers stationed in Eastern Canada, with cases appearing among troops in Nova Scotia and Quebec by 20 September 1918 (see Chapter 1, this volume).

In Canada, the first incidences of influenza outside of the military occurred during late September in eastern cities including Toronto and Montreal (where it arrived on 23 September 1918). However, as it spread rapidly across North America, civilians, too, carried it with them. In Winnipeg, the first civilian case occurred on 30 September, a woman who had recently returned from visiting family in Montreal. She died just one day after a school-aged girl in Toronto (see Chapter 9, this volume).

Canada’s experience during the pandemic was, in a general sense, similar to that of other Western industrialized countries. Its overall mortality rate, at approximately 6.1 deaths for every 1,000 people, was comparable to that of the United States and slightly higher than that of England. The number of dead was nevertheless considerably lower than that of many African and Asian countries, which bore the brunt of the pandemic. It is more difficult to accurately assess the numbers of those infected, but probably one-quarter to one-third of the population contracted the disease. These aggregate figures, however, mask considerable differences in mortality and incidence as shaped by age, locale, social class, ethnicity, and race. For example, research in Canada by scholars including Maureen Lux, Mary-Ellen Kelm, and Ann Herring has demonstrated the disproportionate impact on Aboriginal people living on reserves and in remote communities. Thus, it is impossible to speak of a universal pandemic experience, either globally or within Canada itself.
Unlike that of many European countries, Canada’s public health infrastructure was rudimentary. There was no federal health department (this was established in 1919, partially in response to the pandemic); nor did every province have health departments (often, health was subsumed into other departments, such as immigration, public works, or agriculture). A synchronized national effort by the state to contain and respond to the flu was simply not possible given these fundamental structural limitations. However, health officials did communicate with one another, sharing ideas and frustrations individually and in medical and public health journals. Their transnational connections with US counterparts were critical. Toronto’s medical officer of health, Charles Hastings, travelled to Boston, New York, and Washington to seek out information about the successes of US containment strategies. Winnipeg’s William Boyd, city pathologist, went to the Mayo Clinic in Minnesota to obtain a vaccine for mass immunization.

Most of the human and financial resources that went into pandemic responses came from local governments across the country, with supervision from provincial boards of health. Despite the lack of national coordination, however, public health measures quickly took on a pattern during the pandemic, as communities throughout the country made similar efforts to control its spread. These included school and university closures, cancellation of church services, closures of public places of entertainment (such as theatres, movie houses, and billiard parlours), quarantine and placarding of infected households, and the compulsory wearing of masks in public. As the federal government had introduced a prohibition on the manufacture and importation of alcohol in March 1918, it was not necessary to close bars. Some cities also attempted vaccination campaigns. Although the aetiology of influenza was unknown in 1918 (the workings of the virus were not discovered until 1933), pathologists and bacteriologists developed vaccine serums that included what they believed to be the causative agents of the disease: these comprised bacteria such as streptococci, pneumococci, and Pfeiffer’s bacillus, an organism isolated after the less severe but quite lethal 1889 influenza pandemic. It is difficult to assess the overall effectiveness of these measures, as we cannot know what might have happened in their absence. Any correlation between differing combinations of public health tactics and death rates across the country is as yet unclear.11

During an era that had witnessed significant medical advancements in bacteriology, epidemiology, and surgery, influenza caught medicine off-guard. There were no effective medical treatments for the disease, although
all manner of interventions were tried. These ranged from venesection (bloodletting), to the use of intravenous saline and glucose, to oxygen to help patients breathe. Aspirin was given for fever, along with alcohol and stimulants such as atropine and strychnine. Pain and agitation were managed with cooling baths, chest poultices, or with opium derivatives such as codeine, morphine, heroin, and veronal. What was perhaps most helpful for patients fortunate enough to get it was bed rest, nourishment and hydration, and fever management, provided by nurses. Although influenza was a blow to the prestige of medicine and public health, it was a boon to the reputation and pride of nursing. In its aftermath, nursing leaders correctly pointed out the value of quality nursing care, which in the absence of effective medical intervention was especially important.

Yet, many flu victims, in both urban and rural settings, appear to have received little or no medical or nursing care. The high numbers of those infected with the disease generally overwhelmed hospitals, and they responded by finding temporary spaces (such as hotels or mission houses) where they opened emergency beds, which were exceedingly rudimentary and unsatisfactory for the provision of care. A significant proportion of Canada’s medical and nursing personnel had volunteered for the war effort, leaving hospitals understaffed and lacking in experienced health care providers. Staffing the emergency hospital beds opened in communities throughout the country was thus a challenge. The disease posed a high risk for health care workers, and many doctors, nurses, and ambulance drivers themselves contracted it, further stretching the capacity to adequately respond to it. Many people remained in their homes, where they fought to recover from influenza with the help of family members. Whereas the better-off could afford private physicians or private duty nurses, many others did not have the resources to pay for a doctor, even should one be available. In this pre-Medicare period, the last vestiges of the Victorian sensibility of “less eligibility” also meant that hospitalization and medical care were not easily accessible to working people, who feared the expense of hospital bills and the interrogation of the means test often required to gain hospital admission. Many jurisdictions offered free hospital care during the pandemic, but this was not always made clear to the public.

By the spring of 1919, this variant of influenza had almost disappeared from Canadian communities, although another, much less prevalent, wave occurred during the following winter in some parts of Canada. This prompted an attempt by alarmed medical and public health officials to evaluate what had and had not worked in 1918-19, but their anxiety quickly
faded when the virus lost its strength. For many Canadians, however, the flu had permanently altered their lives, having killed their parents, siblings, and other family members, as well as friends and co-workers. Thousands of Canadian families changed shape to care for orphans, and social welfare institutions were forced to accommodate the needs of influenza widows, widowers, and children. Although we know relatively little about its precise implications for welfare state development, the memory of influenza is embedded in such social institutions as state and family.

**Historiography**

Since the 1990s there has been an explosion in both popular and scholarly interest in the 1918-20 influenza pandemic. It is no longer the “forgotten” epidemic of the twentieth century, at least from the point of view of the quantity of scholarship devoted to it: the field today numbers hundreds of scholarly articles. Canadian scholars have long played an important role in influenza historiography and are particularly well known outside the country for their work on Aboriginal experiences. In the past decade, a significant body of work has been produced in Canada, as elsewhere. There is an emphasis on local or regional case studies, but scholars have benefited from an increasing awareness of experiences globally, as the field grows and matures. As the contributions to this volume attest, Canadian pandemic scholars have always understood their research in a global context.

In a recent historiographic essay on the impact of influenza in Africa, Matthew Heaton and Toyin Falola argue that the literature on the pandemic has developed along two parallel tracks that do not engage in genuine debate with each other. One perspective emphasizes the universality of the pandemic, regardless of place or social context, and is primarily concerned with tracing official health responses (similarly ineffective all over the globe) and overall mortality rates (also generally similar). Heaton and Falola suggest that many studies of the disease have glossed over important variations in its impact, particularly those that attempt to track “diffusion, demographics, and official response.” The other perspective, which can be characterized as a social historical one, explores a series of diverse questions about the pandemic, such as how it affected religious faith, economic development, gender, or race relations. However, Heaton and Falola assert, the social history of the pandemic is fragmented, lacks a coherent analysis, and avoids the thorny question of whether influenza’s impact can best be understood as global or as shaped by unique local conditions.
There is some truth to this schema within Canada; it is also true that scholars disagree in their interpretations of, for example, the significance of social relations. Differing methodologies, too, bring different questions to light: quantitative analyses of diffusion, for instance, generally do not speak directly to issues of memory. To some degree, Canadian scholarship has been unified by the exploration of questions about race, place, class, and gender that have been central to most studies of the pandemic written since the 1990s, and indeed, to social history more broadly. Although some of this work is based in local research, it addresses influenza’s interconnection with social categories that are not explicitly local in nature. For instance, scholars such as Linda Quiney, Magda Fahrni, and Esyllt Jones have taken gender as a critical social relation within community responses to influenza in several Canadian cities and argue that gender roles shaped women’s involvement in volunteer campaigns to provide care to flu victims. Nor is an interest in social difference necessarily disconnected from questions of epidemiology and public health. Scholars continue to improve our understanding of “diffusion, demographics, and official response” by seeking to know, for example, how diffusion affected the most vulnerable members of society, including Aboriginal people, workers, and rural residents. Integral to this work, which arguably takes a social historical approach in challenging a universalist thesis, is a sense that disease incidence and official responses remain an important component of any social history of influenza because they are still at issue and worth debating.

The meaning of the “local” in studies of influenza, as in the history of medicine more broadly, is one important path to resolving the “universal/social” tension identified by Heaton and Falola. Place is often implicit in the historiography, but there remains some work to do in thinking through how and why place matters. Scholars such as Megan Davies have called for a more sustained attention to the local and regional, and a recent issue of the Journal of Canadian Studies edited by Peter Twohig was devoted to the theme of health and regionalism. Certainly, no scholar of the influenza pandemic can ignore the local context, for in the absence of a federal health authority and infrastructure, almost all critical aspects of the public health response were locally developed and implemented. As this collection suggests, local studies remain important in the field. It is hoped that this volume will begin to facilitate a synthesis of the Canadian experience and will enable future discussion about the tension between universal and specific/local interpretations in the history of the pandemic.

Often, historians of the 1918-20 epidemic are frustrated by its continued marginalization in the history of the twentieth century. Its impact (great)
seems out of line with the import (slight) assigned to it by historians. In Canada, many who have written most recently about influenza would not consider themselves primarily historians of medicine or disease: their interest in the pandemic has stemmed more from an effort to understand the social and cultural history of Canada and the place of disease in that history. They have attempted to integrate the history of the pandemic into their understanding of gender, class, and ethnicity as constitutive of social relations in early-twentieth-century Canada and have used those categories to enrich their analysis of the disease. Canadian social history was itself still in the process of development during the 1980s and 1990s as new work on influenza was emerging; as the practice of social history became more methodologically complex, researchers employed new tools and approaches that have proven well suited to the history of health and disease. To some extent, medical history has also shaped social-history practice – for instance, in its insistence on bodily experience as relevant to history. This exchange and dialogue have proven fruitful for our understanding of the influenza pandemic. One excellent example of this is the wide range of sources utilized by recent scholars, including the contributors to this collection. Sources such as newspapers or medical and health department documents often yield little insight into what living through this epidemic was like for ordinary people, or the longer-term impact of the disease. Supplemented by medical and social welfare case files, oral histories, diaries and letters, parish registers, and the records of civil society organizations such as volunteer groups, more meaningful insight into the pandemic is possible.

**The Essays**

Epidemics are of interest to scholars from various disciplines: most obviously, these include epidemiologists and medical researchers but also social scientists such as anthropologists, geographers, and sociologists, and those working in the humanities – historians and literary scholars, for instance. *Epidemic Encounters* embodies this wide-ranging interest in the influenza pandemic and is an implicit argument for the benefits of a multidisciplinary approach. Whereas the geographers and anthropologists represented in its pages are concerned above all with understanding who contracted influenza in 1918-20, who died, and why, the historians included here ask how medical authorities, health care workers, and various levels of the state managed the epidemic, and how individuals experienced
and reacted to it. This diversity of approaches and objectives lends variety to the essays gathered here but, in the end, provides complementary perspectives.

Although tightly focused on a single event – the influenza pandemic of 1918-20, as played out and lived in Canada – this collection of essays exhibits a diversity of approach. A few common threads are nonetheless evident. To begin with, every chapter demonstrates that Canada, as much as any other country, was fully caught up in the pandemic and that much of what we know about it in other places – Britain, the United States, South Africa – holds true for Canada as well. We thus find familiar elements of what has become the overarching global “flu narrative” in all the chapters. At the same time, all the authors would agree, we think, that there was no single experience of the epidemic. Locality and region mattered, as did race, gender, age, and social class. The chapters in this collection remind us of the geographical diversity of Canada: influenza played out quite differently in Fisher River and Norway House, in Montreal, in Winnipeg, in Hamilton, in Quebec’s Arthabaska County, and among the First Nations communities of British Columbia.

*Epidemic Encounters* begins with essays exploring the ways in which various sectors of society – military and medical authorities, health care workers, and even ordinary individuals – responded to the pandemic as active citizens. In Chapter 1, Mark Osborne Humphries reminds us that, in Canada, the pandemic must be understood in the context of the war effort, and more particularly, the implementation and administration of the Military Service Act in the fall of 1918. The Canadian military, he argues, sacrificed individual and collective public health to perceived military needs. The transportation of Canadian recruits infected with influenza to Europe on troopships and, in the case of those intended to form part of the Siberian Expeditionary Force, to Western Canada on trains, contributed to the spread of the epidemic. So, too, did the vigorous enforcement of conscription, particularly in Quebec, during what Humphries calls “the pandemic period.” Any hopes of wartime consensus were soon dashed: the Canadian public, he suggests, was prepared to make some sacrifices in the interest of military necessity but balked when military demands were clearly seen to be harming public health.

In Chapter 2, Linda Quiney focuses on the central question of the organization of the nursing labour force during the pandemic. Women – as family members, neighbours, volunteers, or trained nurses – were vital to the battle against the flu. In most circles, this was seen as only normal,
given gendered assumptions regarding women’s particular aptitude for caregiving, service, and self-sacrifice.15 Arriving, as it did, in the throes of the Great War, the devastation of the pandemic exacerbated an already existing shortage of trained nurses. Volunteers thus stepped into the breach, and qualified nurses, many of whom had fought hard during the first two decades of the century to secure professional status, were “forced,” Quiney writes, “to share their position and status at the bedside during the influenza crisis” (63). In this situation, differences between qualified nurses and dedicated volunteers were blurred; indeed, they were largely imperceptible to members of the public, including flu victims. Professionals and Voluntary Aid Detachment (VAD) nursing volunteers were united by their gender, often by their class background, occasionally by their uniform, and invariably by their appearance of sacrifice in the context of war and epidemic.

In Chapter 3, Magda Fahrni shifts attention from political authorities and health professionals to examine the ways in which ordinary citizens responded to the epidemic. Concentrating on Montreal, she discusses the phenomenon of “public letter writing” — letters from Montreal citizens to their local government and the press, proposing ways of managing the epidemic and reacting to policies adopted by the municipality, the military, and public health authorities. In some ways, her chapter provides an analysis from the bottom up, not because we hear from influenza victims per se, but because we are able to glimpse the responses of some Montreal citizens to state policy. Male, urban, and literate, most of these letter-writers were nonetheless considerably removed from the corridors of power. Some of them took the opportunity to share with local authorities their opinions on public health measures, both during the epidemic and more generally. Others — principally the owners of businesses small or large — were concerned with seemingly more mundane questions such as store opening hours during the epidemic and thus their own livelihood. These letters remind us of the flu’s impact on bread-and-butter issues such as work and pay; Canadians just emerging from the context of “total war” found themselves plunged into one of “total epidemic,” where everyday life was structured, to some degree, by the disease.

In Part 2 of the collection, the authors scrutinize the epidemiological data to arrive at a precise portrait of who fell ill, who died, and how the disease spread. In Chapter 4, Ann Herring and Ellen Korol undertake a detailed analysis of who, exactly, suffered from influenza. They focus on Hamilton, Ontario, employing death registers as their principal source,
which they cross-reference with city directories to ascertain the residence – and by extension, the class position – of those who succumbed to the disease. The argument has often been made that, unlike tuberculosis or typhus, the influenza virus that proved so lethal in 1918-20 did not differentiate according to social class – although in most places, it did so by age, targeting young adults between twenty and forty, and in many parts of the world, it appears to have discriminated by sex, killing more men than women. Scholars who insist on the socially democratic nature of influenza point to the fact that it felled the wealthy as well as the poor, the socially prominent as well as the unknown, and that it swept through tree-lined residential enclaves as well as urban slums. There is some truth to this argument; as Esyllt Jones points out in Chapter 8, her essay on Winnipeg, “no sector of society was entirely immune to the disease” (197). Yet, though her contribution to this collection focuses on a particular middle-class family, she has shown elsewhere that Winnipeg's working-class and immigrant communities were especially hard hit by the epidemic.16 In Chapter 4, Herring and Korol likewise demonstrate beyond a doubt that, although influenza could be found in all parts of Hamilton during the fall of 1918, the poorer north-end districts of this small industrial city suffered greater rates of mortality than their better-off counterparts in the south end. Contrary to what is frequently assumed, then, the pandemic was definitely not socially neutral.

In Chapter 5, Karen Slonim adopts what medical researchers and anthropologists call a “syndemics” approach, examining influenza’s interaction with other co-existing factors and the ways in which this interface affected morbidity, mortality, and the management of the epidemic. She interrogates influenza’s interaction, not just with other infectious diseases, but also with underlying social factors such as community structure, the nature of work, and the degree of access to informal networks of care. She looks at the social organization of two Manitoban Cree communities, Fisher River and Norway House, to understand how the epidemic could play out so differently in two such geographically proximate locales. She argues that better access to informal networks of care was a crucial variable that allowed residents of Fisher River to more easily survive the epidemic than their counterparts at Norway House. Factors such as the mixed economy of Fisher River (agriculture, fishing, and lumbering), the need for the Norway House Cree to trap further and further afield, and the key role played by the Hudson's Bay Company at Norway House may also have been determinant.
In Chapter 6, Francis Dubois, Jean-Pierre Thouez, and Denis Goulet combine an analysis of the data collected by Quebec’s Superior Board of Health in 1918-20 with a close reading of the Montreal daily *Le Devoir* in order to examine morbidity and mortality on a Quebec-wide scale. Their statistical analyses are more detailed than any others that currently exist for Quebec. Among their conclusions is that, compared to the rest of the province, Montreal appears to have suffered from over-mortality. Such a deduction joins the international literature, then, in suggesting that population density was a significant factor for influenza mortality. It also infers the strong possibility that non-lethal incidents of the disease were under-reported. The authors also conclude, extrapolating from province-wide data, that, contrary to what the international literature indicates, sex does not appear to have determined who died in Quebec, as men and women were struck down in roughly equal numbers. A most useful aspect of their discussion is their focus on the 1920 “echo” wave of influenza, which is alluded to in Chapter 3 on Montreal but not seen everywhere in Canada. Although much less severe than the wave that hit Quebec during the autumn of 1918, it was nonetheless significant, lasting from February to April 1920 and killing almost two thousand Quebecers. Dubois, Thouez, and Goulet show that the Quebec regions worst hit by the fall 1918 wave appear to have been largely spared by that of winter 1920, and that the converse was also true. They also point out an intriguing factor noted by Quebec’s medical community shortly after the 1920 wave – that it appears to have killed proportionally far more infants than its fall 1918 counterpart, which was (in Quebec as elsewhere) most devastating for young adults.

Part 3 of this book explores cultural understandings of, and responses to, the epidemic, as well as the ways in which its impact continued to be felt into the interwar years and beyond. If the pandemic was publicly forgotten for most of the twentieth century, it nonetheless lived on in the personal memories and family stories of individuals and communities. The two chapters in this section also suggest that the outbreak tested the limits of early-twentieth-century modernity.

In Chapter 7, Mary-Ellen Kelm analyzes a series of what she calls “flu stories” that were documented through various media in British Columbia during the epidemic and in subsequent decades. The official accounts of fatalities recorded in death certificates, the dramatic and occasionally boosterist articles published in the daily press, the oral histories conducted with elderly residents of Vancouver’s Strathcona neighbourhood during the 1970s, and finally, oral and written narratives produced by First Nations
people to detail their experience with influenza – these various sources attest to the different ways in which the disease affected diverse groups of British Columbians. Kelm sets her own family’s flu story within the framework of the concept of modernity. Modernity, she argues, was marshalled in 1918-19 to explain both the spread of the pandemic, through “modern” lines of communication and “modern” worksites, and the means taken to deal with it – science and medicine. Yet, not all flu stories conformed to this narrative: in those told by First Nations people or by Strathcona residents, for instance, modernity was often absent altogether or incorporated into new hybrid forms. The universal influenza storyline was thus tempered by the peculiarities of local circumstance. Moreover, certain British Columbians – Aboriginals, people of Chinese, Japanese, or South Asian descent, religious minorities such as Mennonites and Doukhobors – were viewed by fellow citizens of Anglo-Saxon background as distinctly unmodern, and thus as potential “reservoirs” of disease.

In Chapter 8, through an examination of one Winnipeg family, the Hamiltons, Esyllt Jones explores the possibility that survivors of the epidemic, and particularly those who had lost loved ones to it, channelled their grief into spiritualism during the interwar years. Historians have frequently attributed the interwar revival of spiritualism to collective mourning in the wake of the Great War, but Jones argues that the even greater number of influenza deaths might well have played the same role. Like Mary-Ellen Kelm, she notes the ways in which the epidemic tested the limits of early-twentieth-century modernity; in a context where modern science and medicine had failed to provide significant solutions, it is possible that contemporaries sought answers in the realm of the spiritual. In exploring the links between the epidemic, death, grief, and spiritualism, Jones’s contribution to this anthology is a pioneering cultural history of the influenza pandemic in the Canadian context.

In Part 4, Epidemic Encounters concludes by evaluating the usefulness of influenza’s history in approaching contemporary struggles against epidemic disease. In Chapter 9, Heather MacDougall compares the efforts of Toronto’s health department to manage the 1918 influenza epidemic with that body’s responses to the SARS outbreak of 2003. Between 1918 and 2003, Toronto changed considerably, becoming a heavily populated, sprawling, multicultural metropolis. Yet, reactions to SARS by the media and the public in some ways resembled those manifested by Torontonians eighty-five years earlier. MacDougall concludes her analysis of the similarities and differences between these two health crises by arguing that
local governments remain crucial in the battle against infectious disease. In 2003, however, the task of Toronto Public Health was complicated by jurisdictional disputes and recent cost-cutting measures implemented by the provincial government. In a postscript written five years after SARS and ninety years after pandemic influenza arrived in Canada, MacDougall reflects on the lessons that today’s public health policy-makers might take from history, and from historians. In the case of SARS, she wonders, “What role did history play in persuading policy-makers, politicians, and the public that an immediate response to epidemic disease was necessary to protect citizens’ health and to maintain the national economy?” (248). Indeed, she asks, is it even “the historian’s responsibility to point out the ‘lessons of the past’? If it is, to whom should her observations be addressed?” (247). These questions pertain equally to the Canadian experience with H1N1 in 2009-10. In their Conclusion, the editors of this volume reflect on the interactions between the 1918-20 pandemic and our recent confrontation with H1N1.

This volume does not exhaust the possible ways of exploring the 1918-20 influenza pandemic in Canada. As Guy Beiner has argued, much remains to be done in the area of cultural histories of the epidemic. Furthermore, none of the authors gathered here tackles the epidemic from an environmental perspective. Pandemic influenza was a prime example of what Susan D. Jones calls the “nonhuman actors [that] have played important roles in ‘making history,’ influencing cultural practices and determining the shape of social institutions.” The potential for environmental histories of the flu is thus substantial. Yet, the essays collected here offer a broad range of perspectives – demographic, political, social, and cultural – on Canadian experiences of illness and death during the waves of influenza that struck between 1918 and 1920. They thus provide significant insight into a pandemic that continues to exert a considerable hold over the popular and scholarly imagination almost a century later.

Notes


1 The Canadian monographs are Eileen Pettigrew, The Silent Enemy: Canada and the Deadly Flu of 1918 (Saskatoon: Western Producer Prairie Books, 1983); and Esyllt W. Jones, Influenza 1918: Disease, Death, and Struggle in Winnipeg (Toronto: University of Toronto Press, 2007). International works include Richard Collier, The Plague of the Spanish Lady: The Influenza Pandemic of 1918-1919 (New York: Atheneum, 1974); Alfred W. Crosby, America’s Forgotten Pandemic: The Influenza of 1918 (Cambridge: Cambridge University Press, 1989); Dorothy A. Pettit and Janice Bailie, A Cruel Wind: Pandemic Flu in America (Murfreesboro,
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5 Mamelund, “A Socially Neutral Disease?” 938.


11 This is the conclusion drawn by Mark Humphries in his recent “The Impact of Non-Pharmaceutical Interventions during a Pandemic Crisis: The Canadian Experience, 1918-1919” (paper presented at the 33rd Annual Conference of the Social Science History Association, Miami, 23-26 October 2008).


Jones, *Influenza 1918*.

Beiner, “Out in the Cold and Back.”

